New Jersey Department of Human Services
Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders
PO Box 807
Trenton, NJ 08625-0807

CLIENT DEMOGRAPHIC DATA

Client Name	Agency Name

1. Source of Client Referral (Check one) (1) ____ ____
   - 00☐Self
   - 01☐Family
   - 02☐Professionals
   - 03☐Long Term Care Facility
   - 04☐Home Care Agency
   - 05☐Hospital Provider
   - 06☐Adult Day Care Center
   - 07☐Social Service Agency
   - 08☐Community Support Group
   - 99☐Other _____

2. Sex 00☐Male 01☐Female (2) ____ ____

3. Client's Date of Birth
   - a. Month ____ ____ (3a) ____ ____
   - b. Year ____ ____ (3b) ____ ____
   - c. Age ____ ____ (3c) ____ ____

4. Client's Primary Diagnosis (dementia) (4) ____ ____
   - 00☐Alzheimer's Disease
   - 01☐Multi-Infarct Dementia
   - 02☐Parkinson's Disease
   - 03☐Huntington's Disease
   - 04☐Creutzfeldt-Jakob Disease
   - 05☐Pick's Disease
   - 99☐Other _____

5. Source of Above Diagnosis (5) ____ ____
   - 00☐Family Physician/ General Practitioner
   - 01☐Neurologist
   - 02☐Psychiatrist
   - 03☐Geriatric Assessment Center
   - 04☐Alzheimer's Assessment Center
   - 05☐Medical Clinic
   - 99☐Other _____

6. When Was Diagnosis Made?
   - a. Month ____ ____ (6a) ____ ____
   - b. Year ____ ____ (6b) ____ ____

7. Client's Current Residence
   - a. County ____ ____ (7a) ____ ____
   - b. State ____ ____ (7b) ____ ____

8. Client's Ethnicity/Race (8) ____ ____
   - 00☐African American
   - 01☐Hispanic
   - 02☐Asian/Pacific Islander
   - 03☐American Indian/Alaskan Native
   - 04☐Non-Minority

9. Client's Current Marital/Relationship Status (9) ____ ____
   - 00☐Never Married
   - 01☐Married
   - 02☐Widowed
   - 03☐Divorced
   - 04☐Separated
   - 05☐Living Together

10. Client's Present Living Arrangements (10) ____ ____
    - 00☐Living Alone
    - 01☐Living in a household with spouse only
    - 02☐Living in a household with others related
    - 03☐Living in a household with others unrelated
    - 99☐Other (Specify) _____

11. Client's Residence (11) ____ ____
    - 00☐Adult Community
    - 01☐House
    - 02☐Condominium
    - 03☐Apartment
    - 04☐Room: Hotel
    - 05☐Mobile Home
    - 08☐Senior Housing
    - 99☐Other/No Response _____

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12. Does Client Rent or Own Present Residence?
00☐Rent 01☐Own 97☐N/A (12) ____ ____

13. Current Combined Annual Income of Client or Client and Spouse (or Spouse Equivalent)
00☐Under $4,999 03☐$15,000 - 19,999 (13) ____ ____
01☐$5,000 - 9,999 04☐$20,000 - 29,999
02☐$10,000 - 14,999 05☐$30,000 and Above

14. Client's General Health Care Payment Mechanism(s) (Check up to 3)
00☐]Medicare Part A 04☐Health Maintenance Organization (14) ____ ____
01☐Medicare Part B 05☐Veterans Administration
02☐Medicaid 99☐Other Health Insurance ____ ____
03☐Private Pay
____ ____

15. Client's Employment Status (check up to 2)
00☐Worked FT 03☐Disabled (15) ____ ____
01☐Worked PT 04☐Never Worked
02☐Retired ____ ____

16. Client's Ability to Perform Self-Care
00☐Independent (16) ____ ____
01☐Independent, W/Minimal Assistance
02☐Independent, W/Moderate Assistance
03☐Independent, W/Maximum Assistance
04☐Dependent

17. Client's Primary Caretaker
00☐Spouse 04☐Friend/Neighbor (17) ____ ____
01☐Son 05☐Volunteer
02☐Daughter 99☐Other _____
03☐Other Relative(s)

18. Primary Caretaker's Employment Status (check up to 2)
00☐Working FT 03☐Disabled 99☐Other (18) ____ ____
01☐Working PT 04☐Never Worked
02☐Retired 05☐Unemployed _____ ____ ____

19. Client's Service Utilization in the Past Six (6) Months (Check no more than 5)
00☐Primary Care or Other Physician 07☐Adult Day Care Services (19) ____ ____
01☐Hospital 08☐Transportation Services
02☐Community Support Group 09☐Medical Clinic ____ ____
03☐Senior Center Services 10☐Psychiatric Clinic
04☐Congregate/Home Delivered Meals 11☐Boarding Home ____ ____
05☐Home Health Care Services 12☐LTC Facility
06☐Homemaker/Chore Services 13☐No Service Utilization ____ ____
____ ____

20. Has Client Been in a Hospital Overnight or Longer in the Last Twelve (12) Months?
00☐Yes 01☐No (20) ____ ____
a. If Yes, Number of Admissions:
00☐1-3 01☐4-6 02☐7 and Above (20a) ____ ____

21. Does Client Currently Have a Regular Physician/Established Health Care Source?
00☐Yes 01☐No (21) ____ ____

22. Client's Other Diagnoses/Problems (List no more than 5; rank in order of importance.)
00☐ ____ Anemia 11☐ ____ Osteoporosis (22) ____ ____ 1st
01☐ ____ Arthritis 12☐ ____ Speech Impairment
02☐ ____ Cancer 13☐ ____ Stroke ____ ____ 2nd
04☐ ____ Diabetes 14☐ ____ Tuberculosis
05☐ ____ COPD 15☐ ____ Visual Impairment ____ ____ 3rd
06☐ ____ Genito-Urinary Problems 16☐ ____ Gastrointestinal Disorder
07☐ ____ Hearing Impairment 17☐ ____ Vascular Disorder ____ ____ 4th
08☐ ____ Heart Disease 18☐ ____ Seizure Disorder
09☐ ____ Hypertension 19☐ ____ Musculoskeletal Disorder ____ ____ 5th
10☐ ____ Hypothyroidism 99☐ ____ Other _____

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23. Initial Date of Entry into Adult Day Care Program

a. Month _____ _____ (23a) _____ _____

b. Day _____ _____ (23b) _____ _____

c. Year _____ _____ (23c) _____ _____

24. Number of Days Per Week of Attendance in Adult Day Care Program
01☐1 02☐2 03☐3 04☐4 05☐5 06☐6 07☐7 (24) _____ _____

25. Sources of Payment for Client's Day Care, Excluding Copay (Check all applicable)
00☐Self 06☐Peer Grouping (25) _____ _____
01☐Family 07☐Alzheimer's Funding (DHS)
02☐Medicaid 08☐Statewide Respite _____ _____
03☐MLTSS 09☐JACC
04☐Older Americans Act 99☐Other _____ _____ _____
05☐SSBG
_____ _____
_____ _____

26. Number of Days of Care/Week to be Provided by DHS - Alzheimer's Adult Day Services Program
00☐1 01☐2 02☐3 03☐4 04☐5 (26) _____ _____

27. Will Client make a Co-Payment?
00☐No 01☐Yes (27) _____ _____

28. Reasons for Attendance (Check up to 4 and rank in order of importance)
00☐ _____ Requires Supervision During the Day (28) _____ _____ 1st
01☐ _____ Respite for Caregiver
02☐ _____ Social Isolation _____ _____ 2nd
03☐ _____ Caregiver's Employment
04☐ _____ Deterioration of ADL _____ _____ 3rd
05☐ _____ Loss of Primary Caregiver
99☐ _____ Other _____ _____ _____ 4th

29. Client's Pattern of Elimination (Check 2)
00☐Total Bladder Control 03☐Requires Assistance-Bowel (29) _____ _____
01☐Total Bowel Control 04☐Absence of Bladder Control
02☐Requires Assistance-Bladder 05☐Absence of Bowel Control _____ _____

30. Client's Mobility Status
00☐Self Ambulatory 03☐Non-Ambulatory Wheelchair (30) _____ _____
01☐Ambulatory with Assistance 04☐Uses Wheelchair-Distance Only
02☐Ambulatory with Walker 99☐Other _____ _____ _____

31. Actions to be Taken During Program Attendance to Deal With Client's Problems
(Check no more than 5; rank those five in order of importance.)
00☐ _____ Counseling (31) _____ _____ 1st
01☐ _____ Therapeutic Exercise
02☐ _____ Personal Care _____ _____ 2nd
03☐ _____ Socialization
04☐ _____ Activity Programming _____ _____ 3rd
05☐ _____ Bowel/Bladder Training
06☐ Cognitive Stimulation _____ _____ 4th
07☐ _____ Health Monitoring
99☐ _____ Other _____ _____ _____ 5th

32. Actions to be Taken to Deal with Family's Current Problems
(Check up to 3 and rank those 3 in order of importance)
00☐ _____ Mental Health Services 05☐ _____ Medical Assistance (32) _____ _____ 1st
01☐ _____ Community Support Groups 06☐ _____ Substance Abuse Treatment
02☐ _____ Respite Care 07☐ _____ Marital/Family Counseling _____ _____ 2nd
03☐ _____ Legal Services 08☐ _____ Geriatric Assessment Center
04☐ _____ Financial Assistance 09☐ _____ None _____ _____ 3rd